Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 31/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Clinton Edward ROGERS*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *on* ***8 August 2019*** *find that the identity of the deceased person was* ***Clinton Edward ROGERS*** *and that death occurred on* ***18 November 2016*** *at* ***Royal Perth Hospital*** *as a result of* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Ms F Allen assisted the Coroner.
Ms R Hartley and Ms P Aloi (State Solicitor's Office) appeared on behalf of the Western Australia Police Force.

Table of Contents

INTRODUCTION **2**
THE DECEASED **3**
Background 3
Criminal and traffic record 3
EMERGENCY DRIVING POLICY **4**
THE ATTEMPT TO STOP THE DECEASED **6**
Events leading up to the pursuit 6
The decision to pursue the deceased 6
The pursuit 7
The crash 9
Assisting the deceased and Ms Kelly 10
The cause of the crash 10
CAUSE OF DEATH **13**
INTERNAL AFFAIRS UNIT INVESTIGATION **14**
COMMENTS ON THE ACTIONS OF POLICE **15**

SUPPRESSION ORDER

On the basis it would be contrary to the public interest, I make an order under s49(1)(b) *Coroners Act 1996* that there be no reporting or publication of the details of any of the versions of the WA Police Emergency Driving Policy and Guidelines, including, but not limited to, any cap on the speed at which police officers are authorised to drive.

INTRODUCTION

1. Clinton Edward Rogers (the deceased) died at Royal Perth Hospital on 18 November 2016 from multiple injuries after he lost control of the motorcycle he was riding and collided with a brick wall. He was 39-years of age.[1]

2. At the time of his death, the deceased was attempting to evade police and pursuant to the *Coroners Act 1996* (WA) (Coroners Act) his death was a "*reportable death*".[2]

3. Further, because the deceased's death may have been caused or contributed to by a member of the Western Australia Police Force (WA Police), an inquest is mandatory.[3]

4. I held an inquest into the deceased's death on 8 August 2019. The documentary evidence adduced included reports by the Internal Affairs Unit (IAU)[4] and Major Crash Investigation Section (MCIS)[5] of WA Police, concerning the circumstances of the deceased's death. The Brief of evidence comprised one volume.

5. The inquest focussed on the conduct of the police prior to the crash, and whether police officers complied with relevant policies and procedures.

6. The following witnesses gave oral evidence at the inquest:

i. Detective Senior Constable Alan Hunt (Officer Hunt);
ii. Detective First Class Constable David Screaigh (Officer Screaigh);
iii. Senior Constable Ian Cutler (Officer Cutler);
iv. Mr Mark McMullan;
v. Detective Senior Constable Charles Morgan (Officer Morgan); and
vi. Detective Sergeant Graham Teather (Officer Teather).

7. At the conclusion of the inquest hearing, I observed that there was nothing in the evidence before me to suggest that police officers contributed to, or caused the deceased's death. At the relevant time the deceased was affected by methylamphetamine and was riding a powerful motorcycle he had just purchased, at excessive speed.

---

[1] Exhibit 1, Vol.1, Tab 6, Post Mortem Report
[2] Section 3, *Coroners Act 1996* (WA)
[3] Section 22(1)(b), *Coroners Act 1996* (WA)
[4] Exhibit 1, Vol. 1, Tab 9, Report - IAU
[5] Exhibit 1, Vol. 1, Tab 3, Report - MCIS

THE DECEASED

Background

8. The deceased was born in Dandenong, Victoria, on 11 August 1977. He had a younger sister and moved to Western Australia with his family in the late 1980s. In his late teens, the deceased was diagnosed with bi-polar affective disorder but was non-compliant with medication. This led to mood swings and depressive episodes and was reportedly why he began using illicit drugs and associating with "*the wrong company*".[6]

9. The deceased was said to be addicted to methylamphetamine. The deceased's family tried to help him overcome his addiction on numerous occasions, but were unsuccessful. The deceased had a son from a previous relationship, with whom he was said to have little contact.[7]

10. The deceased inherited a large sum of money from his father, who died in March 2015. There were indications that the deceased spent some of that money on methylamphetamine.[8,9]

11. The deceased was described as "*an angel with a heart of gold*" who was generous and would never intentionally harm anyone. Although his life was said to be chaotic and full of turmoil, he enjoyed spending time with his family and close friends.[10]

Criminal and traffic record

12. The deceased's criminal and traffic record is extensive with 44 convictions for criminal and traffic offences. The offences included: reckless driving, possession of cannabis, trespass, stealing, breach of bail and driving with a blood alcohol level in excess of 0.08%.[11,12]

13. At the time of his death, the deceased was serving a number of separate disqualification periods from holding or obtaining a driver's licence and was the subject of an eight month suspended imprisonment order imposed on 28 July 2016 in the Perth Magistrates Court.[13]

---

[6] Exhibit 1, Vol. 1, Tab 3, Victimology Report, p1
[7] Exhibit 1, Vol. 1, Tab 3, Victimology Report, p1
[8] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p8
[9] Exhibit 1, Vol. 1, Tab 3, Victimology Report, p2
[10] Exhibit 1, Vol. 1, Tab 3, Victimology Report, p2
[11] Criminal Record - Clinton Edward Rogers
[12] Exhibit 1, Vol. 1, Tab 9, Report - IAU, p18
[13] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p8 & p10

EMERGENCY DRIVING POLICY

14. Emergency driving by officers of WA Police is regulated by TR-07.04 Emergency Driving Policy and Guidelines (the Guidelines).[14] At the relevant time, the Guidelines identified four categories of emergency driving, namely: vehicle interception; priority 2 driving; priority 1 driving and pursuit driving.[15]

15. According to the definitions in the Guidelines, an attempt to stop a motor vehicle for the purpose of law enforcement (vehicle intercept) can become a pursuit when, for whatever reason, the driver of the vehicle being intercepted does not stop when called on to do so.[16]

16. Clearly, pursuit emergency driving carries risks, and as the Guidelines note:

> *All instances of 'Pursuit Emergency Driving' places an onerous duty on police that weighs heavily in favour of the need for prudence, restraint and the absolute commitment to the protection of life.*[17]

17. The Guidelines set out requirements with respect to the qualifications of the pursuit driver, the class of police vehicle which may be used for a pursuit and the obligations of a police pursuit driver, before, during and after the pursuit. A critical aspect of the pursuit is the risk assessment process. Risk assessment means:

> *The process, either mental or written, of obtaining and processing information to determine the degree of risk posed to all involved in the response and management (includes police, road users, the community and the occupants of the target vehicle.*[18]

18. Factors that impact on the risk assessment process include: assessment of threats to the safety of any person, threats to property, the seriousness of the incident, the manner in which the target vehicle is being driven, the competencies of the police driver, road, weather, traffic conditions and the location of the pursuit, including risks to vehicular and/or pedestrian traffic.[19]

---

[14] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines
[15] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.01
[16] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.01
[17] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.1
[18] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.3
[19] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.3

19. It is incumbent upon all officers involved in pursuit emergency driving, either directly (driver) or indirectly (passenger) to make proper assessments of all associated risk before, during and after a pursuit.[20]

20. Pursuant to the Guidelines, the commencement of a pursuit must be communicated to the Police Operations Centre (POC) and regular updates known as SITREPs must be provided during the pursuit. If this does not occur, POC may terminate the pursuit.[21,22]

21. Whilst undertaking pursuits, unmarked police vehicles must use a portable roof mounted blue light (with 360 degree visibility), in addition to any supplementary flashing lights the vehicle is fitted with.[23]

22. When a driver engaged in a pursuit approaches an intersection controlled by traffic lights that are displaying red, the driver of the pursuit vehicle must reduce speed and make an assessment of the risk of proceeding. The pursuit vehicle may only proceed through the intersection when it is safe to do so.[24]

23. Under the Guidelines, a pursuit is terminated when the risk of continuing outweighs the need to obtain the objective of the pursuit. The pursuit may be terminated by POC, the pursuit vehicle driver, a pursuit vehicle passenger, or one of a range of authorised police officers carrying out roles connected with the pursuit. When a pursuit is terminated, the driver of the pursuit vehicle must immediately reduce speed and comply with applicable speed limits.[25]

24. Following a pursuit that results in serious injury or death, an investigation must be carried out by the Superintendent of the IAU. The investigation of the crash includes an assessment of whether the Guidelines and any relevant legislation has been complied with and the appropriateness of the actions of the pursuit driver.[26]

[20] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.3
[21] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.4
[22] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.9.1
[23] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.4.5
[24] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.4.7
[25] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.4.4.4.9.1
[26] Exhibit 1, Vol. 1, Tab 37, TR 07.04 Emergency Driving Policy and Guidelines, para TR-07.04.8.1 & 4

THE ATTEMPT TO STOP THE DECEASED

Events leading up to the pursuit

25. At about midnight on 18 November 2016, detectives from the Mirrabooka Police Station were conducting a routine patrol on Wanneroo Road, Balcatta in an unmarked police vehicle (NM409). Officer Hunt was driving, Officer Screaigh was in the front passenger seat and Officer Ball was in the rear passenger seat (the Officers).[27,28]

26. At about 12.07 am, the Officers saw the deceased riding his motorcycle with a pillion passenger (Ms Kelly) near the corner of Sylvia Street and Wanneroo Road. Both were wearing helmets. The deceased pulled into the carpark of a shop and approached a parked car. Officers saw a backpack, which had been between the deceased and his passenger, about to be handed to the occupants of the car. The Officers were immediately suspicious given the time of day and the fact that motorcycles are commonly used to conduct drug transactions.[29,30]

The decision to pursue the deceased

27. Officer Screaigh was in the process of getting out of NM409 to speak to the deceased when the deceased rode over the carpark curb onto Sylvia Street and accelerated away towards the intersection of Main Street. Officer Screaigh got back in the vehicle and Officer Hunt decided to attempt to intercept the deceased's motorcycle so the Officers could make further enquiries about the deceased's behaviour. Before the deceased rode off, Officer Screaigh saw the deceased turn and look at NM409.[31]

28. As the deceased accelerated away, Officer Hunt activated NM409's emergency lights and sirens and Officer Screaigh attached a 360 degree blue light to the roof of the car. NM409 got within 10 metres of the deceased's motorcycle on Sylvia Street before the deceased turned right onto Main Street and headed in a northerly direction.[32,33] By this stage it was clear that the deceased was not going to stop and Officer Hunt made the conscious decision to conduct a pursuit.[34]

---

[27] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, paras 4-6 and ts 08.08.2019 (Hunt), p5
[28] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Screaigh, paras 4-5 and ts 08.08.2019 (Screaigh), p10
[29] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, paras 7-8, 11 & 15 and ts 08.08.2019 (Hunt), p5
[30] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Screaigh, paras 6-10 and ts 08.08.2019 (Screaigh), p10
[31] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Screaigh, para 11 and ts 08.08.2019 (Screaigh), p10
[32] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, paras 17-21 and ts 08.08.2019 (Hunt), p5
[33] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Screaigh, paras13-16 and ts 08.08.2019 (Screaigh), p10
[34] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, paras 25-27 and ts 08.08.2019 (Hunt), p7

The pursuit

29. Officer Hunt is a 'priority pursuit driver' who completed training to qualify him to conduct pursuits in January 2015. Mandatory online refresher training is conducted every two years and when interviewed by officers from IAU after the deceased's death, Officer Hunt displayed a "*good working knowledge of the Urgent Duty Driving/Pursuit Policy*".[35]

30. Before commencing the pursuit, Officer Hunt conducted a risk assessment which considered road, traffic and weather conditions; the purpose of the intercept; the fact that the deceased was riding a motorcycle; and that he had a passenger. At the relevant time, the road was dry, the weather was fine and streets illuminated by street lights. Traffic at that time of night was minimal.[36,37]

31. As NM409 proceeded north on Main Street, Officer Screaigh contacted POC to advise them of the situation. At the relevant time, the Guidelines did not require police to seek prior permission from POC to initiate a pursuit, but officers were, at that time, required to seek permission to continue it.[38,39,40]

32. Officer Screaigh was able to identify the motorcycle's registration number and POC confirmed that it was registered to an address in Meckering. This further aroused the suspicions of the officers.[41,42,43]

33. As NM409 continued to pursue the deceased, Officer Screaigh communicated with POC and provided a SITREP. Radio communications between police vehicles and POC can be heard by all those with access to a police radio. Officer Screaigh told POC they had observed the deceased engaged in a possible drug deal and were attempting to intercept him. The POC operator told Officer Screaigh that authorisation to continue the pursuit was being sought from the duty inspector.[44,45]

---

[35] Exhibit 1, Vol. 1, Tab 9, Report - IAU, p3
[36] ts 08.08.2019 (Hunt), pp6-7
[37] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Screaigh, para 15 and ts 08.08.2019 (Screaigh), p12
[38] Exhibit 1, Vol. 1, Tab 37, TR-07.04 Emergency Driving Policy & Guidelines
[39] The Guidelines have now been amended so that permission to continue the pursuit is now not required, but an authorised officer at POC can terminate the pursuit at any time.
[40] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Screaigh, paras 17-18 and ts 08.08.2019 (Screaigh), pp10-12 & p14
[41] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Screaigh, para 19 and ts 08.08.2019 (Screaigh), p14
[42] Exhibit 1, Vol. 1, Tab 33, Police Audio Communications Timeline
[43] ts 08.08.2019 (Hunt), p7
[44] ts 08.08.2019 (Screaigh), p12
[45] Exhibit 1, Vol. 1, Tab 33, Police Audio Communications Timeline

34. Meanwhile, Mr McMullan was driving his work van with two passengers in the right-hand lane of Main Street in a northerly direction towards the Amelia Street intersection. This intersection is controlled by traffic lights.[46]

35. Mr McMullan became aware of emergency lights and sirens behind him and saw a single light in the left-hand lane (which he later realised was a motorcycle). He was initially going to move into the left-hand lane but sensibly realised that the motorcycle was approaching too quickly and there would be a collision if he did so.[47]

36. Mr McMullan estimated that the motorcycle passed his van at a speed of 200 kilometres per hour. After it had done so, Mr McMullan moved his van into the right-hand lane.[48]

37. Officer Hunt says NM409 proceeded north along Main Street at a speed at or below that permitted by the Guidelines. Police vehicles are fitted with an 'automatic vehicle locator system' (AVL) which records the location and speed of the vehicle. Data from the NM409's AVL corroborates Officer Hunt's evidence about his speed at the relevant time.[49,50,51]

38. Officer Hunt saw the motorcycle travel through the intersection of Main and Amelia Streets when the traffic lights were amber. When NM409 reached the intersection, the lights had changed to red. Officer Hunt slowed down and noticed a bus on Amelia Street about to enter the intersection. The bus stopped and when it was safe to do so, NM409 proceeded through the intersection and continued the pursuit.[52]

39. Officer Hunt lost sight of the deceased's motorcycle as it travelled up Main Street. NM409 continued on Main Street and as it turned left and travelled in a northerly direction on Wanneroo Road, Officer Hunt deactivated NM409's lights and sirens. Officer Hunt subsequently became aware that the deceased had crashed his motorcycle and returned to the scene.[53]

[46] Exhibit 1, Vol. 1, Tab 14, Statement - Mr McMullan, paras 3-6 and ts 08.08.2019 (McMullan), p23
[47] Exhibit 1, Vol. 1, Tab 14, Statement - Mr McMullan, paras 7-10 and ts 08.08.2019 (McMullan), p23
[48] Exhibit 1, Vol. 1, Tab 14, Statement - Mr McMullan, para 11 and ts 08.08.2019 (McMullan), p23 & p25
[49] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, para 27 and ts 08.08.2019 (Hunt), p6
[50] Exhibit 1, Vol. 1, Tab 36, NM409's AVL data
[51] Exhibit 1, Vol. 1, Tab 12, Statement - Officer Screaigh, para 19
[52] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, paras 28-31 and ts 08.08.2019 (Hunt), p6
[53] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, para 32-33, 35 & 39 and ts 08.08.2019 (Hunt), p6

The crash

40. As Mr McMullan approached the right hand bend on Main Street that leads to the intersection with Wanneroo Road, he saw the deceased's motorcycle become airborne and then move sideways to the left. The motorcycle's brake lights did not illuminate. Although he did not see the incident that resulted in the deceased's death, Mr McMullan came upon the scene soon afterwards and stopped his van on Main Street.[54]

41. The deceased's motorcycle was lying on its side, partly on the footpath and partly in the garden of 509 Main Street.[55] The deceased was lying face up in bushes on the boundary between 507 and 509 Main Street, whilst Ms Kelly was lying in the foetal position in the garden of 509 Main Street.[56,57]

42. Investigators from MCIS attended the scene and noticed a series of scuffs and scrapes in the grass verge and the driveway of 505 Main Street and on the footpath which may indicate some braking. Investigators concluded that the deceased had been travelling north on Main Street before leaving the roadway and travelling over the driveway at 505 Main Street before travelling over the grass verge and footpath. The evidence suggests that the motorcycle continued on before striking the brick wall dividing 507 and 509 Main Street and coming to rest.[58]

43. Investigators calculated that the deceased's motorcycle travelled 34 metres from the driveway at 505 Main Street, before coming to rest at 509 Main Street. The motorcycle sustained damage to its left hand side, although when subsequently inspected by vehicle examiners, it was found to have no defects other than crash damage.[59,60]

44. CCTV obtained from houses along Main Street shows the deceased's motorcycle travelling at speed, followed nine seconds later by NM409. It follows that NM409 was not in the vicinity of the deceased's motorcycle when it crashed.[61] Ms Kelly said she saw NM409 drive past with its lights and sirens activated about a minute and a half after the crash.[62]

---

[54] Exhibit 1, Vol. 1, Tab 14, Statement - Mr McMullan, paras 17-18 & 23-24 and ts 08.08.2019 (McMullan), p24
[55] Exhibit 1, Vol. 1, Tab 28, Report - Initial collision assessment (MCIS)
[56] Exhibit 1, Vol. 1, Tab 14, Statement - Mr McMullan, paras 25-26 & 28 and ts 08.08.2019 (McMullan), p24
[57] ts 08.08.2019 (Cutler), p21
[58] Exhibit 1, Vol. 1, Tab 28, Report - Initial collision assessment (MCIS)
[59] Exhibit 1, Vol. 1, Tab 28, Report - Initial collision assessment (MCIS)
[60] Exhibit 1, Vol. 1, Tab 26.2, Vehicle Examination Report
[61] Exhibit 1, Vol. 1, Tab 9, Report - IAU, p12
[62] Exhibit 1, Vol. 1, Tab 10, Statement - Ms Kelly, para 26

Assisting the deceased and Ms Kelly

45. To his very great credit, after stopping at the crash scene, Mr McMullan went to the assistance of the deceased and Ms Kelly. He heard Ms Kelly cry out in pain and realised she was alive and breathing. In accordance with his first aid training, Mr McMullan attended to the deceased, who was not making any noise and was clearly more seriously injured. Mr McMullan says the deceased's eyes were open but glazed over and he was unable to find a pulse.[63]

46. A short time later, Senior Constable Cutler, who had been patrolling separately in the area and had heard the POC transmission about the crash, arrived on the scene and assisted with CPR. Ambulance officers then arrived and took the deceased to Royal Perth Hospital (RPH) where he was declared dead at 12.56 am on 18 November 2016.[64,65,66]

47. Meanwhile, the Officers, who were travelling north on Wanneroo Road, heard radio transmissions indicating that the deceased had not been seen on Wanneroo Road. As a result, NM409 began patrolling the back streets of Balcatta on the assumption that the deceased had probably turned into a side street to avoid detection.[67] A short time later, the Officers heard a POC transmission about the crash and drove to the scene.[68]

The cause of the crash

48. A report completed by Officer Morgan (who was attached to MCIS at the time), concluded that speed, drugs and inexperience had contributed to the deceased losing control of his motorcycle.[69]

49. In terms of speed, there is no way of knowing exactly how fast the deceased was travelling at the relevant time. However, on the basis of the evidence of Officer Hunt and Mr McMullan and the AVL data from NM409, I conclude that the deceased was travelling at excessive speed prior to the crash.

50. Toxicological analysis of post mortem samples found methylamphetamine (at a level of 1.5 mg/l) in the deceased's system.[70]

---

[63] Exhibit 1, Vol. 1, Tab 14, Statement - Mr McMullan, paras 25-26 & 28-34 and ts 08.08.2019 (McMullan), p24
[64] Exhibit 1, Vol. 1, Tab 16, Statement - Officer Cutler, paras 3-30 and ts 08.08.2019 (Cutler), pp17-19 & p22
[65] Exhibit 1, Vol. 1, Tab 29, St John Ambulance - Patient Care Record
[66] Exhibit 1, Vol. 1, Tab 4, Life extinct form & RPH Death in Hospital Form
[67] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, paras 36-38
[68] Exhibit 1, Vol. 1, Tab 11, Statement - Officer Hunt, para 39
[69] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p10
[70] Exhibit 1, Vol. 1, Tab 7, ChemCentre toxicology report

51. The Brief included a report from Professor Joyce, (an eminent clinical toxicologist), which related to a person other than the deceased. For that reason, the contents of the report were of limited value, however, Professor Joyce expressed the opinion that a methylamphetamine level of 0.64 mg/l was: "*quite a lot higher than the average concentration found in impaired drivers*."[71] The deceased's level was obviously higher still.

52. Methylamphetamine is stimulant drug which is popularly abused because of its capacity to produce a feeling of euphoria, well-being and confidence. Intoxication with methylamphetamine can cause a person to become over-active, talkative, agitated and cause trembling. Risk-taking behaviour, recklessness aggression and violence can occur in the early stages of intoxication.[72]

53. After the period of acute stimulation has passed, slowness, inattention and impaired reactions are common.[73] Thus, either way, methylamphetamine consumption is incompatible with safe and responsible road use.

54. I note that Ms Kelly confirmed that the deceased had used amphetamines prior to the crash, but did not indicate when.[74]

55. On the basis of the available evidence. I find that at the time of the crash, the deceased had a level of methylamphetamine in his system which impaired his ability to control his motorcycle.

56. The deceased's motorcycle was a powerful machine which he had purchased on the day he died.[75] Officer Morgan, an experienced police motorcyclist who had in fact owned the same model motorcycle as the deceased, described it as a: "*monster and a brute*".[76,77]

57. Officer Morgan said that the deceased's motorcycle required an experienced rider and noted that riding a motorcycle with a passenger is more difficult than riding solo. This is especially so when the passenger is inexperienced and doesn't know how to lean correctly when the motorcycle is cornering.[78,79]

---

[71] Exhibit 1, Vol. 1, Tab 8, Report - Professor David Joyce, p3
[72] Exhibit 1, Vol. 1, Tab 8, Report - Professor David Joyce, p2
[73] Exhibit 1, Vol. 1, Tab 8, Report - Professor David Joyce, p2
[74] Exhibit 1, Vol. 1, Tab 10, Statement - Ms Kelly, para 32
[75] Exhibit 1, Vol. 1, Tab 10, Statement - Ms Kelly, para 7
[76] ts 08.08.19 (Morgan), p29
[77] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p8
[78] ts 08.08.19 (Morgan), pp29-30
[79] Exhibit 1, Vol. 1, Tab 3, Report - MCIS, p8

58. The deceased did not have a licence to ride a motorcycle[80] and immediately before the crash, Ms Kelly said:

> *I tried to get Clint to stop, I was screaming at him to stop. We were going really fast and Clint wasn't good at going around bends and the motorbike was too powerful.*[81]

59. Following the crash, investigating officers found $1,016.65 in cash and 0.5 grams of methylamphetamine in the deceased's possession. Considering that that the deceased was the subject of a suspended imprisonment order and several disqualifications from obtaining or holding a driver's licence at the time of the crash, the deceased had good reason to want to avoid being stopped by police.[82,83,84]

60. On the basis of the evidence before me, I am satisfied that the deceased crashed as a result of riding at excessive speed on a powerful motorcycle he had recently purchased whilst impaired by methylamphetamine.

[80]
[81] Exhibit 1, Vol. 1, Tab 10, Statement - Ms Kelly, paras 18-19
[82] Exhibit 1, Vol. 1, Tab 9, Report - IAU, p23
[83] Criminal Record - Clinton Edward Rogers
[84] Exhibit 1, Vol. 1, Tab 9, Report - IAU, p18

CAUSE OF DEATH

61. The deceased was visually identified by his mother in the presence of Senior Constable Cobanov at Royal Perth Hospital at 5.40 am on 18 November 2016.[85]

62. On 21 November 2016, a forensic pathologist (Dr McCreath), conducted a post mortem examination of the deceased's body. Dr McCreath found multiple injuries, including: lacerations to the deceased's heart, pericardial sac, liver, kidneys and aorta and blood in his chest and abdominal cavities.[86]

63. The deceased was also found to have fractures of multiple ribs, his sternum and his left arm and there was evidence of an old injury to his brain.[87]

64. Toxicological analysis found methylamphetamine along with its metabolite amphetamine in the deceased's system. Alcohol and other common drugs, including cannabis were not detected.[88]

65. At the conclusion of the examination, Dr McCreath expressed the opinion that the cause of death was multiple injuries.

66. I accept and adopt the opinion of Dr McCreath as to the cause of death.

67. I find that death occurred by way of accident.

[85] Exhibit 1, Vol. 1, Tab 2, Identification of deceased person form
[86] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[87] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[88] Exhibit 1, Vol. 1, Tab 7, ChemCentre toxicology report

INTERNAL AFFAIRS UNIT INVESTIGATION

68. Officer Teather, who was attached to the IAU at the relevant time, conducted an investigation into the crash and the conduct of the Officer to identify any breaches of legislation or policy in relation to police actions.[89]

69. After receiving a phone call about the matter, Officer Teather attended the scene and subjected the Officers to drug and alcohol testing. In each case, the tests were negative.[90]

70. Officer Teather subsequently interviewed each of the Officers as well as Ms Kelly, Mr McMullan and one of Mr McMullan's passengers. Officer Teather also obtained statements from attending police, officers from MCIS and the vehicle examiners and reviewed CCTV footage, crash scene photographs, AVL data, records of police communications, St John Ambulance patient care records, the post mortem report and toxicology results.[91]

71. Officer Teather noted that the pursuit had commenced at 12.07:23 am, and that in a broadcast to POC at 12.08:28 am (less than one minute later), Officer Screaigh said:

> *Yeah roger, we've downgraded mate we've lost them, were in a priority one pursuit yeah we've lost em.*[92]

72. Officer Teather concluded that the reason why the occupants of NM409 did not see the crash was that the deceased's motorcycle was nine seconds ahead, and the deceased had already crashed by the time NM409 had reached the crash scene. The Officers were focussed on the road ahead where they quite reasonably assumed the deceased was still travelling. Further, Officer Hunt was negotiating the sweeping right hand bend on Main Street prior to Wanneroo Road intersection, and was quite properly giving that activity his full attention.[93]

73. Officer Teather concluded that the Officers had reacted to the deceased's motorcycle appropriately and whilst attempting to intercept the deceased, had: "*complied with legislation and WA Police emergency driving policy*".[94]

---

[89] Exhibit 1, Vol. 1, Tab 9, Report - IAU
[90] ts 08.08.19 (Teather), p38
[91] Exhibit 1, Vol. 1, Tab 9, Report - IAU, pp17-18
[92] Exhibit 1, Vol. 1, Tab 33, Police Audio Communications Timeline
[93] Exhibit 1, Vol. 1, Tab 9, Report - IAU, pp22-23
[94] Exhibit 1, Vol. 1, Tab 9, Report - IAU, p24

COMMENTS ON THE ACTIONS OF POLICE

74. In this case, police had good reason to suspect that the deceased's actions in stopping his motorcycle in the carpark next to a vehicle at around midnight on 18 November 2016 were suspicious. They attempted to speak to the deceased, but he obviously realised that NM409, though unmarked, was a police vehicle.

75. The speed at which the deceased rode away from the carpark indicated a conscious decision on his part that he did not intend to stop for police. He had good reason to evade police. He was subject of a suspended imprisonment order and several driver's licence disqualifications, did not have a licence to ride the motorcycle and was in possession of a quantity of cash and methylamphetamine.

76. The deceased was affected by methylamphetamine, was riding a very powerful motorcycle which he had purchased earlier that day and was riding at a speed which was significantly in excess of the posted speed limit. As he entered a sweeping right hand bend on Main Street, he lost control of his motorcycle and crashed into a brick wall.

77. After reviewing the evidence, I accept that NM409 was some distance behind the deceased's motorcycle and had passed the scene after the crash had already occurred. Further, I accept that the Officers did not see the deceased or Ms Kelly lying on the ground, because they were focussed on the road ahead. As soon as the Officers became aware that the crash had occurred, NM409 drove to the scene and the Officers assisted with enquiries.

78. After careful consideration of the evidence before me, I am satisfied that the Officers did not contribute to, or cause the death of the deceased. In my view, their actions were, in all of the circumstances, reasonable.

79. The impact of the deceased's loss on his family and friends is incalculable. The tragic outcome in this case resulted from the deceased's decision to ride a powerful motorcycle at excessive speed whilst affected by methylamphetamine.

MAG Jenkin
Coroner
15 August 2019